



**Texas Department of Insurance**  
**Division of Workers' Compensation**  
Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:  HARRIS METHODIST HOSPITAL 3255 W PIONEER PKWY ARLINGTON TX 76013	MFDR Tracking #: M4-07-2788-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  AMERICAN HOME ASSURANCE CO Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Requestor's Position Summary:** "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the APC rate of \$1704.59 for APC number 154. Allowing this at 140% would yield a fair and reasonable allowance of \$2386.43."

**Principal Documentation:**

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - \$1159.80

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Respondent's Position Summary:** "It is the Respondents position that the Requestor was paid more than a fair and reasonable amount as determined in accordance with the criteria for payment under the **ACT**. Specifically, the amount paid by the Respondent was more than that which would be allowed under Medicare. Respondent has paid Requestor \$1118.00 which is the same amount that full service hospital would be paid for its facility charges associated with a spinal surgery and a one-day inpatient hospitalization."

**Principal Documentation:**

1. DWC 60 Package
2. Payment screen of additional \$229.34 paid on 2/13/2007

### PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
1/16/2006	W10, W4, W3, W1, NSU7	Outpatient Surgery	\$1159.80	\$0.00
			<b>Total Due:</b>	<b>\$0.00</b>

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on January 4, 2007.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
  - W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology. Reduced to fair and reasonable.

- W4-No add'l reimbursement allowed after review of appeal/reconsideration. Reimbursement for your no additional monies are being paid at this time. Bill has been paid according to state fee guidelines or rules and regulations. [sic]
  - W3-Additional payment made on appeal/reconsideration. Reimbursement for your resubmitted invoice is based upon documentation and/or additional information provided.
  - W1-F-When medically necessary, implantables & orthotics and prosthetics are reimbursed at cost to the hospital plus 10% per the Texas Acute Care Inpatient Hospital Fee Guideline, page 70.
  - W1-Workers Comp state fee sched adjust. Reimbursement based on Medicare fee schedule amount for facilities. [sic]
  - NSU7-Additional monies are being paid at this time. Bill has been paid according to state fee guidelines or rules and regulations.
2. Division rule at 28 TAC §134.401(a)(4), effective August 1, 1997, states "Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements."
  3. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
  4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
  5. Division rule at 28 TAC §133.307(e)(2)(C), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission." Review of the documentation submitted by the requestor finds that the requestor has indicated that the amount billed for the services in dispute is the total for all services charged on the hospital bill; however the documentation does not support that all of the services in dispute were rendered on the date of service listed on the requestor's *Table of Disputed Services*. The requestor listed the disputed date of service as 1/16/06 on the *Table*; the total charges on the bill were for date of service 1/13/06, 1/14/06 and 1/16/06. The Division concludes that the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under Division rule at 28 TAC §133.307(e)(2)(C).
  6. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
  7. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
    - The requestor's position statement states that "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the APC rate of \$1704.59 for APC number 154. Allowing this at 140% would yield a fair and reasonable allowance of \$2386.43."
    - The requestor does not discuss or explain how payment of 140% over Medicare would result in a fair and reasonable reimbursement.
    - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
    - The requestor did not list the carriers or provide supporting documentation that this methodology is accepted by most carriers.
    - The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
    - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to

support the proposed methodology.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(2)(C), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311  
28 Texas Administrative Code §133.307, §134.1, §134.401  
Texas Government Code, Chapter 2001, Subchapter G

#### **PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services involved in this dispute.

#### **DECISION:**

_____	_____	<b>9/9/2010</b>
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

#### **PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**